

# Creating a Culture of Wellness in a Rural Healthcare Setting for Patients who are HIV+

CommWell Health  
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# North Carolina

## 17 Clinics: Medical-Dental- Behavioral Health (some are stand alone)



**Counties served:** Bladen, Sampson, Johnston, Lee, Harnett, Wake,  
Cumberland, New Hanover, Brunswick, Wayne, Robeson

# The Who, What, Why, How, When of CommWell Health

Mission: Compassionate Delivery of Quality Medical, Dental and Behavioral Health for all

Vision: To be recognized and respected as a premier Community Health Center in the Nation

## Accreditations

Primary and behavioral health care services by Joint Commission (since 2000)

Federally Qualified Health Center

# CULTURE

## Core Values:

- Collaborative Leadership
- Teamwork
- Value Everyone
- Learning Environment
- Continuous Improvement
- Integrity

## Core Competences: (Three C's)

- Culture of Excellence & Accountability
- Creative & Transformational Thinking
- Compassionate Care

# Your Patient Centered Health Home

## Affordable Primary Care Services

### Medical:

Maternity Care, Gynecology, Pediatrics, Internal Medicine  
and Infectious Disease, Family Medicine, Radiology,  
Laboratory, HIV/AIDS Care, WIC and Pharmacy Services



### Dental:

Preventative Care,  
Cleanings, Fillings,  
Restorations



All Services at CommWell  
Health are offered by a fully  
certified and bilingual staff  
providing culturally  
sensitive and quality  
care for all people!



### Behavioral Health:

Residential Substance Abuse Rehab Program for Men  
In-Patient Substance Abuse Treatment  
Comprehensive Out-Patient Substance Abuse Treatment  
Intensive Treatment Programs  
DWI Assessment and Treatment  
Transitional Housing Program for Women  
Counseling Services  
Psychiatric Services  
Walk-In Crisis Center

*CommWell Health is committed to quality care and quality improvement.*

## Comprehensive Team-Based Care

### Team Communication:

- ✓ Daily "Fly ins" (Huddles)
- ✓ Encrypt Messages
- ✓ PCMH weekly huddles

### Primary Care Team Members

- PATIENT, Primary Care Provider, Nurse, Health coach, LCSW, Pharmacist, Nutritionist, Referral Specialist, Interpreter (as needed), SPNS (as applicable)

The Primary Care Team provides support, education, and resources to meet the patient's needs.

## Access

### CommWell Health offers:

- Walk-In Availability for Medical & Behavioral Health
- On call Medical & Dental Providers - 24/7 Nurse Triage Access for Patients
- Centralized Scheduling ( 1-877-WELL-ALL)
- Online health services through our Patient Portal via secure messaging
  - Online appointment scheduling
  - Access to medical records
  - Medication renewals
- After-Hours Line for Behavioral Health
- Extended hours (Thursday evenings and Saturdays)
- Consumer Advisory Board ensures patients' voice guides service delivery.

# Positive Life Program

- The Positive Life Program of CommWell Health was created to improve the quality of life for those infected and affected by HIV/AIDS.



# Positive Life Program

- We strive to provide comprehensive, confidential, and culturally sensitive healthcare to all of our patients.
- Our goal is to provide these services with respect and compassion while advocating for our patients and working to break the stigma and prejudices associated with HIV/AIDS.

# History

- The Positive Life Program was established in 1987.
  - Over the years the program has grown and developed into a well established nationally recognized program.

# Positive Life Team

- Infectious Disease Specialist, MD
- Positive Life Supervisor
- Clinical Care Coordinator , RN
- Medical Case Managers
- Data Quality Analyst
- Treatment Adherence Specialist
- Service Coordinator
- Bridge Counselor

# Positive Life Team

Clinic is held on Thursdays and Fridays.

Thursday the Positive Life Team has an interdisciplinary meeting including

- Infectious Disease Specialist (MD)
- Clinical Care Coordinator
- SPNS Project Manager
- Behavioral Health Specialist (LCAS and/or LCSW)
- Medical Case Managers
- Data Quality Analyst
- Treatment Adherence Specialist
- Any other service providers (e.g. dentist, pharmacist, nutritionist)

# Wellness Services

- Outpatient Medical Care
- AIDS Drug Assistance Program (ADAP) and Pharmaceutical Assistance (PAP)
- Oral Health Care
- Behavioral Health Care
- Medical Case Management
- Treatment Adherence Services
- Support Groups and Peer Education

# Culture of Wellness

- We have created a stable health home for our patients encouraging active participation in their health care and optimal patient outcomes.

# Cervical Cancer

## Clinical Quality Improvement

- Project implemented in May 2012.
- HAB 07 Cervical Cancer Screening with a 90% benchmark goal established by NC .
- This is an annual screening for patients with at least one medical visit in the measurement year.
- Patients <18 yrs. old and denied sexual history of sexual activity or patients who had a hysterectomy for non/dysplasia/non malignant indications were excluded.

# Cervical Cancer

## Barriers

- Patients are not prepared for their PAP during medical visit.
- Patients would indicated they had it performed with another agency
- Patients did not keep their appointment.



# Cervical Cancer

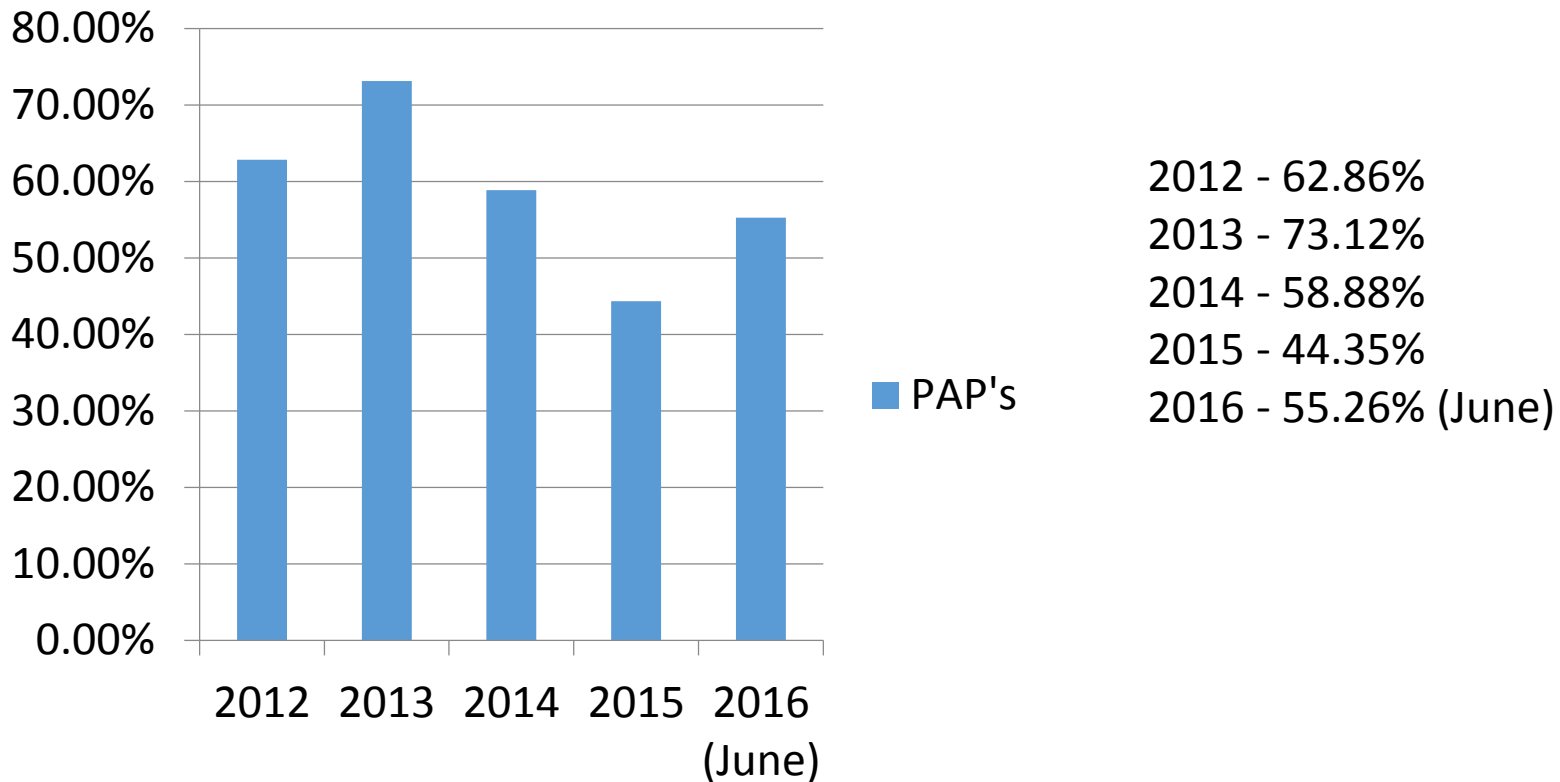
## Solution

- CommWell hired a fulltime OB/GYN in May 2012.
- The patients were able to be seen and tracked within the electronic health record (EHR) system.
- The consults were being conducted between the ID Specialist and OB/GYN.

**In 2015 the benchmark goal for cervical cancer screenings was reduced to 60%.**

# Cervical Cancer Data

## PAP's



# Oral Health Quality Assessment

## Clinical Quality Improvement

- In 2012, CommWell Health recognized their oral health screening produced an unacceptable rate of 27.39% with a population of 249.
- The Core Quality Committee committed to an organizational benchmark of 70% through incremental increases over 12 months.
- A structured process was implemented towards enhancing the staff knowledge of desired oral health inputs, output and outcomes.

# Internal Barriers – Organization Related

- Fragmented oral health service allocations across 4 different budgets with limited collaborative efforts towards unduplicated services
- Scattered documentation in electronic records of oral health screenings, treatments and outcomes for PLWHA
- Limited funding capacity for transportation assistance solely for dental appointments

# External Barriers – Client Related

- Lack of knowledge related to the benefit of oral health screening, prompt oral health treatment and risk associated with the advancement of poor oral health while living with HIV
- Continued stigma related to the diagnosis of HIV, fear of dental procedures and limited beliefs about oral health as a priority
- Transportation cost, distance and reliability

# HAB Performance Measure – Oral Exam

## **Numerator:**

Number of patients with a diagnosis of HIV who had an oral exam by a dentist during the measurement year, based on patient self-report or other documentation

## **Denominator:**

Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year

Guide for HIV/AIDS Clinical Care. U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Published January 2011.

Accessed August 26, 2013. Available at: <http://hab.hrsa.gov/deliverhivaidscale/clinicalguidelines.html>

# AIM Statement

“Tri-County Health will improve the rate of oral health screening and treatment to people living with HIV/AIDS. This enhancement will be accomplished through consistent efforts that identify routine process improvements. We anticipate incremental increases in the rate of oral health screenings within 3 months (September 2012) and steady increases within 1 year. Our benchmark will be set at 70%, which will require a 43% increase from our efforts.”

## PDSA MODEL – Plan / Do

Initiated an Oral Health Campaign to educate clients on the benefits of screening and treatment

- Demonstrated proper oral health techniques
- Instructed on self-monitoring of oral cavity and potential disease manifestations



# PDSA MODEL – Plan / Do

Conducted staff training to wage stakeholder buy-in (organization officials, medical, nursing, medical case management) and consistent participation;

- Defined HAB performance measures for Oral Health
- Demonstrated data collection and the process of analysis for improvement

# Plan / Do Continued

Incorporated a dental hygienist into routine scheduling to conduct oral health screenings, routine cleanings and patient education on a weekly basis during medical clinics;

- Coordinated with medical and nursing staff in a co-located exam room to minimize wait times
- Coordinated dental treatment appointments with medical appointments to minimize travel needs and cost
- Developed a co-partnership between dental and medical services minimizing the potential for fragmentation of care

# Study / Act

Developed a timeline for evaluation;

- Runs random sample data on a monthly basis to review process success of oral health screening
- Monitors progress of implementation through staff and client feedback
- Re-implements aspects of program as needed

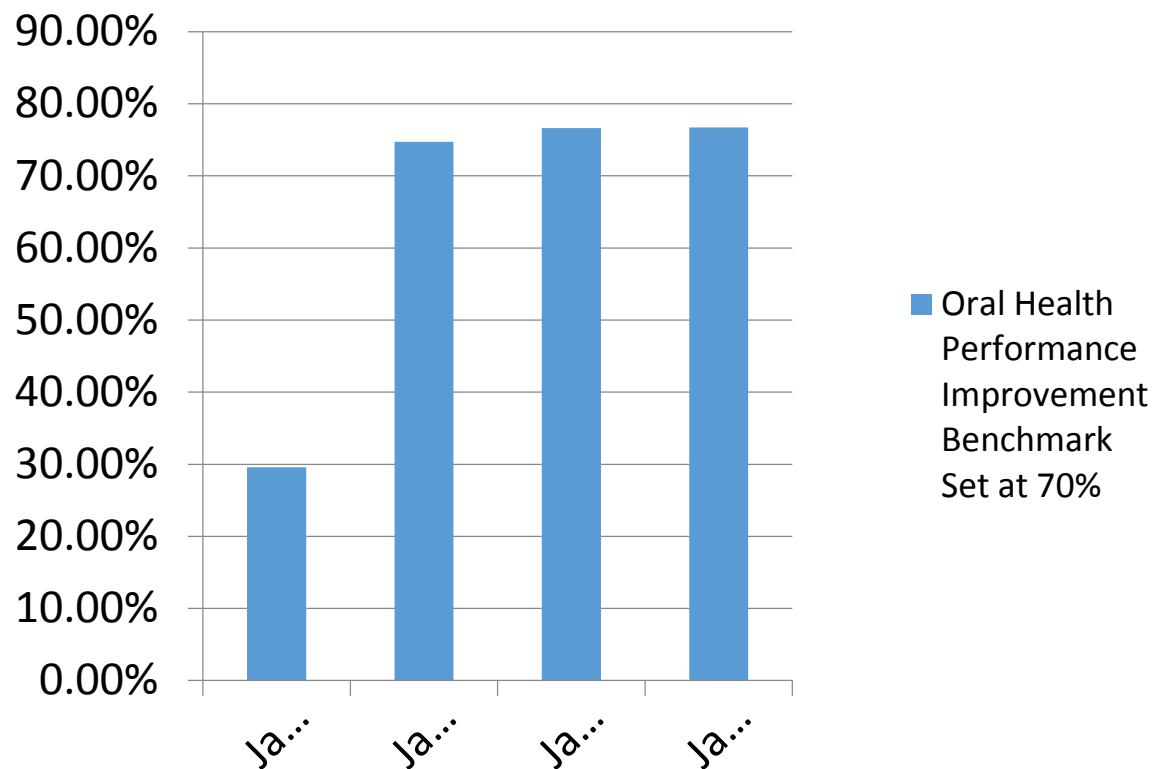
# Study / Act

- Enhanced oral health screening and treatment;
- Streamlined the scheduling of dental appointments and maximized the efforts of the dental provider
  - Improved oral health documentation and data collection for Ryan White Service Report needs
  - Improved oral health outcomes for those living with HIV

# Data Results

## N = 378

### Oral Health Performance Improvement Benchmark Set at 70%



Jan 2012 – 29.56%  
Jan 2013 – 74.73%  
Jan 2014 – 76.62%  
Jan 2015 – 76.71%

# Other Successes

- Prioritized dental appointments as urgent or routine which organizes and maximizes the scheduling of the dental provider
- Identified cost savings and un-duplication of services
- Eliminated transportation cost for separate medical and dental appointments
- Collaborative efforts between Part C & D for service delivery of oral care

# Next Steps

- Continue to enhance staff knowledge of clinical quality management as it relates to Ryan White performance measures, reporting and active participation in the National Quality Center nationwide initiatives
- Continue the momentum of success to other clinical and non-clinical program improvement areas
- Identify and involve a consumer in ongoing programmatic CQM activities
- Share best practices about our culture of wellness!

- **Ethnicity**

- Hispanics 64
- Non-Hispanics 314

- **Race**

- White 131
- Black 244
- Asian 1
- Pacific Islander 0
- American Indian 2

- **Gender**

- Males 252
- Females 126
- Transgender 0

- **Poverty Level**

- Below Poverty Level 275
- 100 – 138% 45
- 139 – 200% 38
- 201 – 250% 7
- 251 – 400% 12
- 401 – 500% 0
- >500% 0

- **Housing Status**

- Stable 366
- Temporary 1
- Unstable 11



# RSR 2015 Continued

- **Poverty Level**

■ Below Poverty Level	275
■ 100 – 138%	45
■ 139 – 200%	38
■ 201 – 250%	7
■ 251 – 400%	12
■ 401 – 500%	0
■ >500%	0

- **Housing Status**

• Stable	366
• Temporary	1
• Unstable	11

- **Risk Factor**

• MSM	147
• IDU	14
• Heterosexual	249
• Transfusion	6
• Perinatal	2

- **Medical Insurance**

• Private	40
• Medicare	49
• Medicaid	86
• VA / Tricare	4
• No Insurance	238

# Retention – Viral Load Suppression 2015

## Performance Measure

- Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load < 200 copies/mL at last viral load test during the measurement year

**DOGWOOD HEALTHCARE NETWORK REVIEW OF RYAN WHITE CLIENT RECORDS  
FOR VL SUPPRESSION QM PROJECT**

Client Name/ID#	Date Reviewed:
Current Viral Load value:	Reviewer Name:

Client Measurement	Yes	No	Please Comment
2 Viral Load tests at least 3 months apart within the prior 12 months:			In CAREWare? YES NO
Is client on ARV's and how are they paid for:			
Has Geno/Pheno been drawn?			
Is the client receiving primary medical care? Where?			
Client is involved with MCM, supportive CM, TAC, Care Coordinator (who and where)			
Last contact with the above staff			
Client keeps scheduled appointments			ALWAYS SOMETIMES RARELY
Documentation of issues with transportation			
Documentation of mental health issues (referrals done)			
Documentation of substance abuse			
Plan:			
90 day review: VL value			

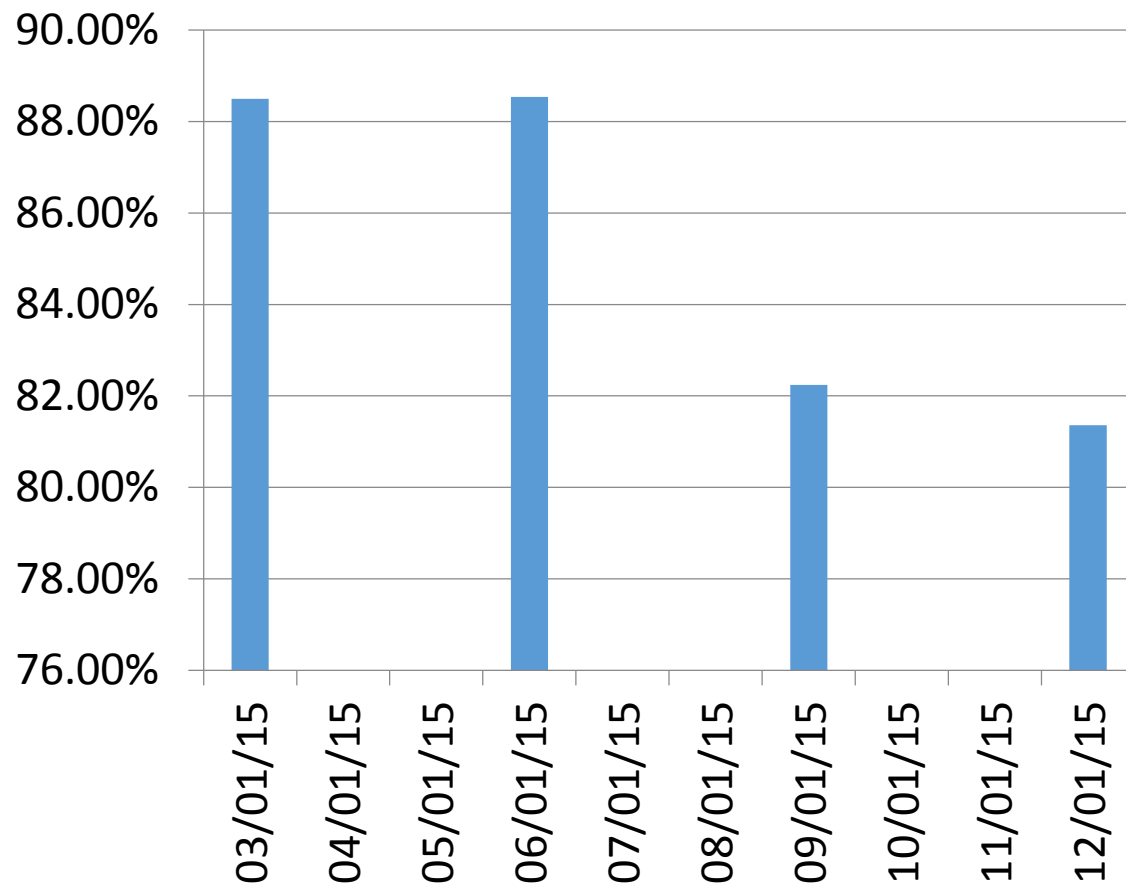
**Chart Audit Tool**

# Analysis and Looking Ahead (next Steps)

## Trends

- Chart Review conducted monthly
- Individual Patients
  - Identify patient barriers
  - Develop person-centered plan
  - Coordinate referrals for service, transportation, etc.
  - Leverage C and D services / funding (e.g., Bridge Counseling)
- Patients not Virally Suppressed – Schedule appointment ASAP

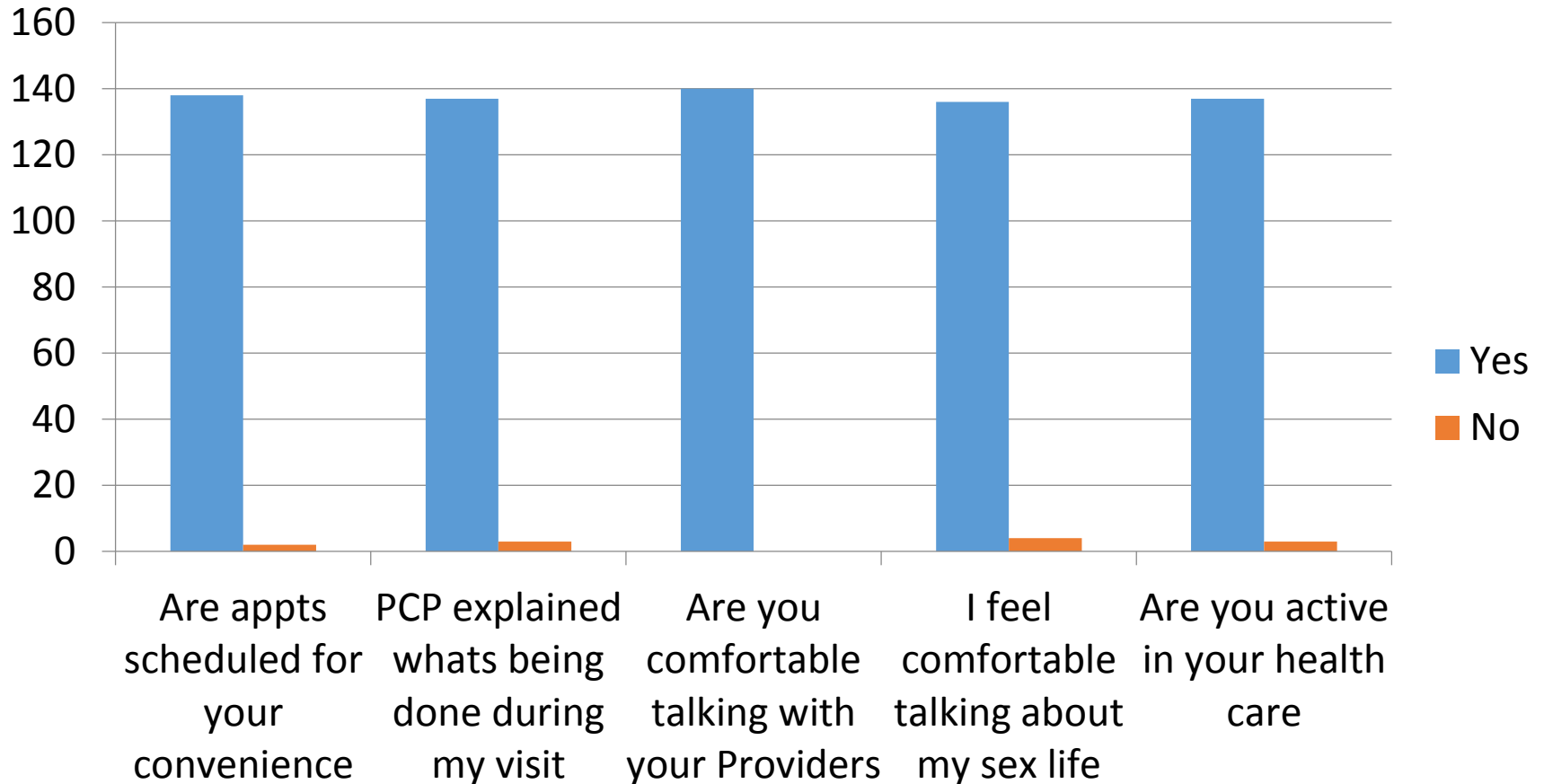
# Viral Load Suppression- NC01



**3/31/15 – 88.50%**  
**6/30/15 – 88.54%**  
**9/30/15 – 82.24%**  
**12/31/15 – 81.36%**

# Client Satisfaction Survey 2016

## N = 140



# Case Management Duties

- Intakes-enroll newly diagnosed/existing patients in Positive Life Program
- Make appointment reminder calls and follow-up calls for missed appointments
- Coordinate the expansion and revision of the resource network
- Screen all clients annually and periodically (ADAP ,Financial eligibility and the acuity scale)

# Acuity Plan

- Acuity scale covers clients nine different life areas:
  1. Healthcare coverage
  2. Housing
  3. Transportation
  4. Income
  5. Legal Issues
  6. Social support/resources
  7. Risk Behaviors
  8. Substance abuse
  9. Mental health



# Case Management

- Provide risk reduction counseling with patients and partners if needed.
- Connect patients to services based on acuity scale..
- Follow up with patients to make ensure they are still satisfied with goals as well as following through with goals that were set.
- If client contacts MCM with a health concern. MCM will contact the provider about the patient's concerns.
- Contact clients that are not undetectable.

# Client Assistance

- Provide Bill assistance through HOPWA (STRMU/TBRA)
  - Rent, utility assistance and water bills
  - Refer to Local DSS for LIEAP assistance with light bills.
  - Refer clients to local community organizations for bill assistance with includes: crisis centers, faith based organizations, and Salvation Army.

# Food

- Assist clients with applying for food stamps.
- Transport clients to local food banks.
- Provide clients with lunch during medical appointments.

# Resources

- Assist clients with applying for Disability and Medicaid.
- Refer patients to Rex Mammogram Bus, and eye appointments
- Refer patients to CWH Behavioral Health Services
- Housing (HOPWA, Section 8,shelters(based on client situation)
- Free legal services
- Refer client to CWH or Medicaid Transportation

# Consumer Advisory Board

- The Consumer Advisory Board (CAB) was created in November 2006
- The purpose of the CAB is to provide a consumer perspective and represent the community in making sure that activities are carried out in a way that best meets the consumers needs.
- Goals:
  - Identify barriers and solutions to any problems between Consumer/Providers in a timely manner.
  - Promote HIV/AIDS Awareness and Education for all Communities.

# Task Force

- Non profit volunteer organization founded in 1992
- Supports Sampson Co residents diagnosed with HIV/AIDS
- Provides supportive services such as: emergency funding for bill assistance, and emotional support for families.
- Provides information about HIV/AIDS to the community.

# Support Group

- Women's support group
  - Third Tuesday of the month
  - Pharmaceutical companies, PL Staff, and CWH staff teach classes
  - Various topics: Mammograms, HIV and mental Health, Risk reduction
- Co-ed support group
  - Second Tuesday of the month
  - Therapeutic education through Pharmaceutical companies, PL Staff, and CWH staff
  - Various topics: HIV and Aging, nutrition, smoking cessation.

# Service Coordinator

- Assists MCMs with the clients HIV care.
- Meet with newly diagnosed clients and facilitate entrance into HIV care.
- Provide emotional support for newly diagnosed clients
- Educate client and clients family about HIV
- Make home and or hospital visits
- Assist clients with transportation needs



# Bridge Counselor

- Link newly diagnosed or clients that have been lost to care to medical and supportive services
- Link to medication assistance or community resources
  - ADAP, PAPs, food banks
- Provide Home Visits

# ADAP

- MCMs and the Treatment Adherence specialist enroll clients in the AIDS Drug Assistance Program (ADAP) and recertify them twice a year.
- Enroll clients in Patient Assistance Programs (PAP).
- File current invoices from Walgreens for medications patients receive through the ADAP Program
- Coordinate medication deliveries with service coordinator.

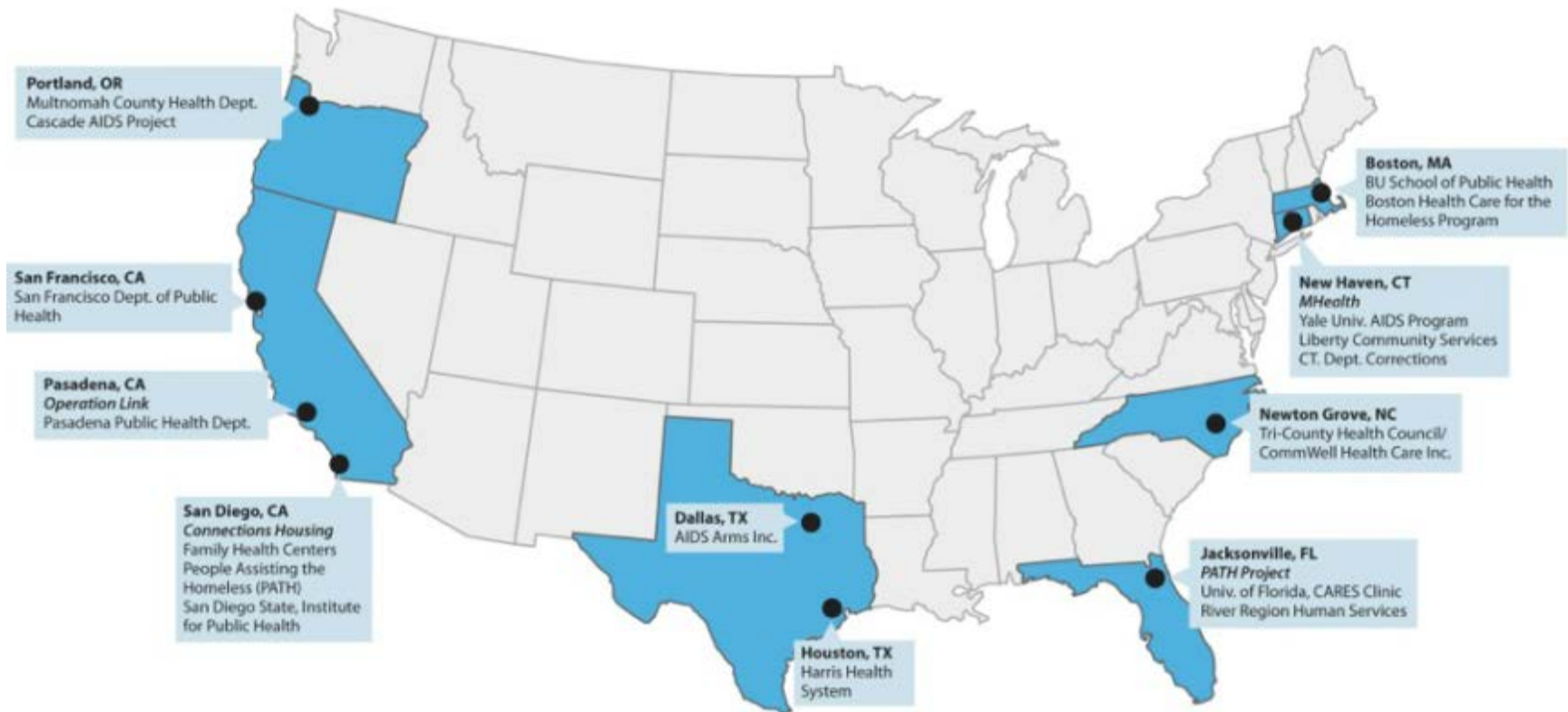
# Treatment Adherence

- Review Labs
  - Provide patients with CD4 and Viral load levels
- MCM will schedule a meeting with clients that do not adhere to medication regimen.
  - MCM assists client with adherence strategies based on clients lifestyle such as:
    - Pill boxes
    - phone applications
    - encouraging clients to take medication at the same time everyday.

Clinical Care Coordinator screens patients for adherence at each regularly scheduled appt and on an annual basis.

# Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations (2012-2017)

## HRSA/SPNS Initiative: Building a Medical Home for HIV Homeless Populations



# Study Coordinator

- **Performs interviews sessions with study participants under supervision of the Project Manager and Principal Investigator.**
- **Maintains study participants files.**
- **Coordinates scheduling of participant study visits.**
- **Conducts informed consent and interviews with study participants.**

# Enrollment & Retention

<u>Enrollment &amp; Retention</u> Status 7/25/16	Total
Total actively enrolled	80
Completed study participation	15
Lost to follow up	4
Incarcerated	0
Out of state	3
Migrant Farmer (Out of State)	0
Hospitalized	0
Withdrawn (voluntarily)	0
Withdrawn (administratively)	1
Grand total	80

FU1- 3 month	86 %
FU2- 6 month	88%
FU3- 12 month	83%
FU4- 18 month	90%

# Network Navigators

- Works closely with the HIV care team to foster culture of wellness
- Conducts Community Outreach
- Engages and recruits
- Connects participants to community housing and support services
- Builds partnerships in the community
- Provides transportation

# Continuum of Care Coordinator

- Works in tandem with the Infectious Disease/HIV Specialist to ensure the necessary referrals are initiated and appointments are scheduled.
- Conducts and updates the project participant's culturally competent care plan.
- Participates in data collection and quality improvement activities as appropriate.
- Coordinates the involvement of project participants in chronic disease self-management activities.



# Community Outreach



# Community Housing Coalition



# Culture of Wellness

[https://drive.google.com/file/d/0Bz\\_z2msMzlgUV01QYnY5aFhOUzg/view?usp=sharing](https://drive.google.com/file/d/0Bz_z2msMzlgUV01QYnY5aFhOUzg/view?usp=sharing)

# Contact Information

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- ✓ Positive Life
- ✓ SPNS
- ✓ Boston University
- ✓ HRSA